SUMMARY PLAN DESCRIPTION

FOR

CITY OF MEMPHIS RETIREE PRIVATE EXCHANGE HEALTH REIMBURSEMENT ARRANGEMENT

[NOTE: This document is structured as a separate stand-alone plan under ERISA. If a particular employer desires to incorporate the HRA as part of an existing ERISA retiree health plan, the employer will need to make revisions to this document. Further, this HRA is not intended to be part of an ERISA plan that covers employees.

This document is provided to the employer for convenience only. It has not been reviewed or approved by the Internal Revenue Service or the Department of Labor. The employer should consult with legal counsel to prepare its summary plan description. Towers Watson neither provides legal nor tax advice, nor represents that this document is appropriate for a particular employer.]

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INTRODUCTION

The Sponsor has established a Health Reimbursement Arrangement (the "Plan") for the benefit of its retirees and the retirees of its participating affiliates. (The Sponsor and participating affiliates are collectively referred to herein as the "Employer"). The purpose of the Plan is to reimburse eligible retirees for certain medical expenses and health insurnace premiums which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description ("SPD") is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor's offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Sponsor.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

PART I
GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan, except for those Eligible Prescription costs reimbursed through the coverage gap, generally are excludable from the Participant's taxable income.

Q-2. Who can participate in the Plan?

Retired employees of the Employer are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree as defined in Section 1 of the Plan Information Appendix. Eligible Retirees who become covered under the Plan, as explained in Q-4, are called "Participants."

Note that certain self-employed persons (such as sole proprietors, partners and 2% shareholders of an "S" corporation) may not participate in the Plan. In addition, you are not eligible to participate in the Plan unless you are classified by the Employer as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former employee of the Employer.

Q-3. Can my dependents participate in the Plan?

If your Sponsor elected to make separate Benefit Credits for your Eligible Dependents, as reflected in Section 3 of the Plan Information Appendix, your Dependents who meet all requirements to be Eligible Dependents may also become Participants in the Plan. Note that your Sponsor may require that you be a Participant in the Plan before your Eligible Dependent may become a Participant. See Section 4 of the Plan Information Appendix for whether this rule applies to you and your Eligible Dependents.

If your Sponsor does not elect to make separate Benefit Credits for your Eligible Dependents, as reflected in Section 3 of the Plan Information Appendix, they may not become Participants in the Plan, but you are still entitled to be reimbursed from your HRA Account for any Eligible Medical Expenses you incur on behalf of your Eligible Dependents. This is explained more in Q-6 below.

Your Dependents generally include your legal spouse and any other individual who is your dependent for federal income tax purposes at the time of your retirement. Your Dependents may also include your children up to a certain age as reflected in Section 2 of the Plan Information Appendix. You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan. In addition, the Plan will allow reimbursement of Eligible Medical Expenses for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made.

You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator at the address listed in the Plan Information Appendix.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Retiree or, if the Sponsor has elected to make Benefit Credits for Eligible Dependents, as reflected in Section 3 of the Plan Information Appendix, an Eligible Dependent actually becomes a Participant in the Plan on the later of the Effective Date of the Plan as provided in the Plan Information Appendix or the date that he or she has satisfied all of the following requirements:

- He or she has become eligible for Medicare;
- He or she has obtained an individual health insurance policy through Towers Watson (or any of its affiliates) or, if permitted by the Sponsor as reflected in Section 5 of the Plan Information Appendix, he or she has provided satisfactory evidence to the Plan Administrator that he or she has other coverage permissible to the Plan Administrator;
- He or she has completed any enrollment forms or procedures required by the Plan Administrator; and
- For non-Medicare eligible individuals, the effective date that he or she has opted into receiving Benefit Credits as provided below.
- For non-Medicare eligible individuals that are eligible for Benefit Credits, as reflected in Section 3 of the Plan Information Appendix, an Eligible Dependent cannot become a Participant in the Plan until he or she has opted-into receiving Benefit Credits under the Plan (and such election has become effective). If a non-Medicare eligible individual is also eligible for the Federal Advance Premium Tax Credit (APTC), he or she must elect to receive Benefit Credits or the APTC for the applicable time period. For any applicable time period, a non-Medicare eligible individual cannot receive both the APTC and Benefit Credits under this Plan.

Q-5. How does the Plan work?

If the Sponsor has elected a Combined Account structure, as reflected in Section 6 of the Plan Information Appendix, one HRA Account will be established for all Participants in your family. Benefit Credits for all Participants in your family will be credited to that HRA Account.

If the Sponsor has elected a Separate Account structure, as reflected in Section 6 of the Plan Information Appendix, a separate HRA Account will be established for each Participant in your family and Benefit Credits for each Participant in your family will be credited to his or her own HRA Account.

Benefit Credits will be credited to HRA Accounts by the Employer in the amount and at the times specified in Sections 7 and 8 of the Plan Information Appendix and will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Employer's general assets.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you or any Eligible Dependent for medical care, as that term is defined in Internal Revenue Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities);
    - Medications are considered Eligible Medical Expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin.
    - This Plan only reimburses expenses for covered Part D prescription drugs to the extent that Catastrophic Coverage Reimbursement applies as set forth in the Plan Information Appendix. If Catastrophic Coverage Reimbursement does not apply, then no reimbursement for covered Part D prescription drugs will be made.

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance purchased through Towers Watson or an affiliate.

Some examples of common items that are <u>not</u> Eligible Medical Expenses include:

- Premiums for medical, prescription drug, dental, vision or long-term care insurance purchased outside Towers Watson or an affiliate, unless an exception is granted;
- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues (unless specific requirements are satisfied); and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items may or may not be Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical

Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix. The Plan Administrator (and its delegates) determine solely what is an Eligible Medical Expense.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only Eligible Medical Expenses incurred while your Eligible Dependent is a Participant in the Plan may be reimbursed from his or her HRA Account. (Note that, even if your Eligible Dependent is not a Participant in the Plan because the Sponsor has chosen not to make Benefit Credits for the Eligible Dependent, you are entitled to obtain reimbursement from your HRA Account for Eligible Medical Expenses incurred by or on behalf of your Eligible Dependents.) Eligible Medical Expenses are "incurred" when the medical care is provided, not when you or your Eligible Dependent are billed, charged or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g. pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may <u>not</u> be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred for covered Part D prescription drugs;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- any other expenses specifically identified as excluded in Section 9 of the Plan Information Appendix.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by the Employer as an active employee;
- if you were eligible for Medicare, the date thereafter that you cease to be eligible for Medicare (unless you remain eligible under another provision of the Plan);
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

If you are an Eligible Dependent, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Dependent for any reason;
- if you were eligible for Medicare, the date thereafter that you cease to be eligible for Medicare (unless you remain eligible under another provisions of the Plan);

- in the case of an Eligible Dependent spouse, the date you divorce the Eligible Retiree;
- the date of the Eligible Retiree's death, if the Sponsor ceases to make Benefit Credits to you, as reflected in Section 11 of the Plan Information Appendix;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of "incurred," see Q-6.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, your Eligible Dependents may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Their continuation of coverage rights and responsibilities are described in Q-16 below.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will either be forfeited or carried over to subsequent Plan Years, as reflected in Section 10 of the Plan Information Appendix.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred and (e) name of provider. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent.

If the Sponsor elected not to allow amounts to be carried over to the next Plan Year, as reflected in Section 10 of the Plan Information Appendix, you must submit requests for reimbursement of Eligible Medical Expenses by March 31 following the Plan Year in which the expense is incurred.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

The Claims Submission Agent shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit twelve months after the check was mailed or the payment was otherwise attempted.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to HRA Account benefits, the claim or action must be brought within 18 months of the date of the denied appeal.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim.

Q-11 What happens if I die?

Combined Account

If the Sponsor elected the Combined Account structure as shown in Section 6 of the Plan Information Appendix, and the Eligible Retiree dies with no Eligible Dependents who are

Participants in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

If the Eligible Retiree dies with one or more Eligible Dependents who are Participants, his or her HRA Account shall continue and the Eligible Dependents who are Participants can continue to submit Eligible Medical Expenses for reimbursement if the Sponsor elected to continue making Benefit Credits to such Eligible Dependents after the Eligible Retiree's death, as reflected in Section 11 of the Plan Information Appendix. If the Sponsor did not elect to continue making Benefit Credits to such Eligible Dependents after the Eligible Retiree's death, as reflected in Section 11 of the Plan Information Appendix, then the HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

Separate Account

If the Sponsor elected a Separate Account structure, as reflected in Section 6 of the Plan Information Appendix, and the Eligible Retiree dies, the HRA Account of the Eligible Retiree is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

If the Sponsor did not elect to continue making Benefit Credits to such Eligible Dependents after the Eligible Retiree's death, as reflected in Section 11 of the Plan Information Appendix, then the HRA Accounts of such Participants are also immediately forfeited upon the Eligible Retiree's death, but the deceased Eligible Dependent's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death. If the Sponsor elected to continue making Benefit Credits to such Eligible Dependents after the Eligible Retiree's death as reflected in Section 11 of the Plan Information Appendix, then the Eligible Dependents may retain their HRA Accounts and submit claims for Eligible Medical Expenses in the normal course.

In the event an Eligible Dependent who is also a Participant dies, his or her HRA Account shall be immediately forfeited, but the deceased Eligible Dependent's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before the Eligible Dependent's death. Claims must be submitted within 180 days of his or her death.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Sponsor expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, and to reduce or eliminate the amount credited to HRA Accounts in the future.

Employers participating in the Plan other than the Sponsor (such as a related affiliate of the Sponsor) may terminate their participation in the Plan at any time upon 60 days written notice to the Sponsor and Plan Administrator.

Q-15. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by an employer, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

Q-16. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," Eligible Dependents under the Plan who are the spouse, former spouse or dependent child of a Participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant's death or a dependent child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If an Eligible Dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA

Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA Account is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Employer ceases to provide any group health plan.

Q-17. What is alternative coverage?

The Sponsor may make available to a qualified beneficiary (as defined in Q-16 above) other coverage in lieu of the continued coverage described in Q-16 above. The Sponsor will provide more information on any alternative coverage that may be available under the Plan upon the occurrence of a qualifying event (as defined in Q-16 above).

If the qualified beneficiary chooses the continuation coverage above, he or she waives the right to the alternative coverage. If the qualified beneficiary chooses the alternative coverage, he or she waives the right to continuation coverage as described above.

Q-18. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

Q-19. What about Catastrophic Coverage Reimbursement?

If set forth in the Plan Information Appendix, Catastrophic Coverage Reimbursement is provided under this Plan. Catastrophic Coverage Reimbursement begins after you have reached the higher of –

- The Catastrophic Coverage level as defined by Medicare for the applicable year; or

- The level set by the Plan Administrator as set forth in the Plan Information Appendix.

Catastrophic Coverage Reimbursement can be obtained by contacting the Third Party Administrator and requesting a claim form.

Catastrophic Coverage Reimbursement will be administered and paid according to one of the following options. The specific option that applies is set forth in the Plan Information Appendix.

(Option One) Once you reach the Catastrophic Coverage Reimbursement level, the Sponsor will make a one-time contribution to your HRA Account. This amount can be found in the Plan Information Appendix. The one-time amount is allocated to your HRA Account, after which you can file eligible claims for reimbursement of qualifying prescription drug expenses. All other HRA Account rules discussed in this SPD continue to apply.

(Option Two) Each year a set amount of money is designated by the Sponsor for the catastrophic reimbursement pool for all Eligible Retirees and Eligible Dependents. All eligible claims incurred during the year and submitted within the applicable timeline will be totaled and receive a proportionate amount of the pool. As an example if the pool contained $100,000 and there were $200,000 in claims all participants would receive a 50% reimbursement. Reimbursements will be paid after all eligible claims have been submitted for the applicable year. The amount of the pool can be found in the Plan Information Appendix. The pool and eligible claims are administered separate from your HRA Account, but all other applicable HRA Account rules continue to apply.

(Option Three) Once you reach the Catastrophic Coverage Level for an applicable year, all eligible claims for qualifying prescription drug expenses will be reimbursed without any dollar limits. Claims must be incurred during the applicable Plan Year and submitted within the time frame set forth in this SPD for other qualifying HRA Account claims. All other HRA Account provisions set forth in this SPD continue to apply.

Q-20. What about Coverage during the Medicare Part D Gap?

Sponsor may provide additional reimbursement if you reach the Medicare Part D coverage gap. The coverage gap is defined by Medicare for the applicable year. If you have additional expenses related to prescription costs as a result of the coverage gap you may be able to obtain additional reimbursement by contracting the Plan Sponsor. Once you reach the coverage gap for an applicable year, all eligible claims for qualifying prescription drug expenses will be reimbursed without any dollar limits. Claims must be incurred during the applicable Plan Year and submitted within the time frame set forth in this SPD for other qualifying HRA Account claims. All other HRA Account provisions set forth in this SPD continue to apply. Any payments received under this provision may be considered taxable income.

PART II

This Plan is a governmental employee welfare benefit plan as defined in Section 414(d) of the Internal Revenue Code,l The plan is not governed by Employee Retirement Income Security Act of 1974, as amended ("ERISA"). However, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations upon prior request and appointment with the Plan Administrator and during reasonable business hours, all documents setting forth the terms and provisions of the Plan and governing the Plan..

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents in accordance with the governing terms of COBRA continuation coverage if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Enforcement of Your Rights

If your claim for a welfare benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under the Plan, or if you need assistance obtaining documents from the Plan Administrator, you should contact your Human Resources Department

PART III
LEGAL NOTICES

Health Insurance Portability and Accountability Act

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or "Protected Health Information" ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" or "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is materially changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for plan administrative purposes or as otherwise permitted by federal law. This notice only applies to Protected Health Information or PHI as defined in the applicable HIPAA privacy rules.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for plan administrative purposes or as otherwise permitted by law. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the protected health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; or
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.

- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
-
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that

the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

- For research, subject to conditions.

- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notwithstanding the above, and to the extent provided in applicable law, the Plan shall not use or disclose your PHI that is classified as genetic information for purposes of any underwriting activity.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person

on your behalf has paid the health care provider and you have not requested reimbursement from the Plan.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a "Designated Record Set" or "DRS." The DRS is the group of records maintained by or on behalf of the Plan contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Sponsor that duplicates information maintained by a Plan business associate in its DRS.

The Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing.

If you exercise your right to access your PHI, the Plan will respond to your request within 30 days, subject to a one-time extension of an additional 30 days. In the case of an extension, the Plan must provide you with a written explanation for the delay and the date by which it will respond to your request.

The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

C. Right to Amend PHI

If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (except where you are unable to request an amendment from the person or entity that created the PHI because the person or entity is no longer available); (2) the Plan determines the information to be accurate or complete; (3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, a description of your right to submit a statement of disagreement and a description of your right to file a complaint with the Plan or with the Department of Health and Human Services.

D. Right to Receive an Accounting of PHI Disclosures

You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an authorization; or (4) disclosures prior to April 14, 2003 (or the inception of the Plan, whichever is later).

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. This time period may not be longer than six [6] years and may not include any disclosures of PHI made before April 14, 2003 (or the inception of the Plan, whichever is later). The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: Notice of Breaches of Unsecured PHI

Under HIPAA, the Plan and its business associates, are required to maintain the privacy and security of your PHI. The goal of the Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as "breaches." If a breach affects you and is related to unencrypted PHI, the Plan or its applicable business associate will notify you of the breach and the actions taken by the Plan or the business associate to mitigate or eliminate the exposure to you.

Section 5. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 7. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

PLAN INFORMATION APPENDIX

GENERAL PLAN INFORMATION

Name of Plan:	City of Memphis Retiree Private Exchange Health Reimbursement Arrangement
Effective Date:	March 1, 2017
Name, address, and telephone number of the Plan Sponsor:	City of Memphis 2714 Union Ext., 5th Floor, Suite 100 Memphis, TN 38112
Name, address, and telephone number of participating Employers (other than Sponsor):	Memphis Shelby County Airport Authority 4225 Airways Blvd. Memphis, TN 38116
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	City of Memphis 2714 Union Ext., 5th Floor, Suite 100 Memphis, TN 38112
Agent for Service of Legal Process:	Memphis City Attorney 125 N. Main Street, Room 406 Memphis, TN 38103
Sponsor's federal tax identification number:	TIN 62-6000361
Plan Number:	Plan #1
Plan Year:	2017
Third Party Administrator:	Towers Watson 10975 South Sterling View Drive South Jordan, UT 84905

	(866) 322-2824 Medicare.OneExchange.com/Employer

Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	Towers Watson P.O. Box 25181 Lehigh Valley, PA 18002-5181 Fax: 1-866-886-0878
Funding:	Benefits are paid from the Employer's general assets or from the City of Memphis OPEB Trust Fund.

PLAN TERMS

1. Eligible Retiree: Eligible Retiree means:

(a) A former employee of the Employer who has satisfied the following requirements as of his or her retirement:

(1) x Completed 25 Years of Service (as defined in the Plan)

(2) x Attained age of 60 with 10 years of services or age 65 with 5 years of service.

(3) x Attained 12 years of service as an appointed employee.

(4) ☐ Other (specify):_____

(b) The following former employees are not Eligible Retirees:_____
_____

2. Dependents:

(a) x A Dependent also includes a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree until (1) ☐ the date of, (2) x the end of the month in which occurs, or (3) the end of the calendar year in which occurs,

the child's 26th birthday.

(b) ☐ N/A.

3. Benefit Credits for Eligible Dependents:

(a) x Yes

(b) ☐ No

An Eligible Dependent for whom the Sponsor elects to make a Benefit Credit is eligible to be a Participant under the Plan.

4. Eligible Dependent: An Eligible Dependent may be a Participant in the Plan:

(a) x only if and when the Eligible Retiree becomes a Participant

(b) ☐ regardless of whether the Eligible Retiree is a Participant, but the Dependent must not participate in another group health plan sponsored by the Company

5. Insurance Coverage Exception: In lieu of obtaining an individual health insurance policy through Towers Watson, an Eligible Retiree or Eligible Dependent may establish that he or she:

(a) ☐ Has health coverage under TRICARE

(b) ☐ Has health coverage under a policy or plan provided by his or her spouse's employer

(c) ☐ Resides outside the United States

6. Account Structure:

(a) x *Combined Account*. Only one HRA Account will be established for all Participants in a single family and all credits for such family members will be credited to such HRA Account.

(b) ☐ *Separate Accounts*. A separate HRA Account will be established for each Participant within a single family.

7. Benefit Credit:

(a) The following annual amount will be credited on behalf of Participants who are Eligible Retirees:

(1) x Discretionary, to be determined in the sole discretion of the Company each Plan Year

(2) ☐ Fixed Dollar Amount of $_____

(b) The following annual amount will be credited on behalf of Participants who are Eligible Dependents:

(1) x Discretionary, to be determined in the sole discretion of the Company each Plan Year.

(2) ☐ Fixed Dollar Amount of $_____ for Dependent Spouses.

(3) ☐ Fixed Dollar Amount of $_____ for Dependents other than Spouses.

(4) ☐ (Specify formula):_____

8. Timing of Benefit Credit: Benefit Credits will be credited to HRA Accounts as follows:

(a) ☐ One time on (insert date):_____

(b) x On the first day of each Plan Year

(c) ☐ On the first day of each calendar quarter (i.e., one-fourth of the annual Benefit Credit 9 will be credited each quarter)

(d) ☐ On the first day of each calendar month (i.e., one-twelfth of the annual Benefit Credit will be credited each month)

9. Health Care Expense Exclusion: Health Care Expenses do not include the following: _____

10. Carryover of Accounts: Credits remaining in an HRA Account at the end of a Plan Year (after the expiration of the claims run-out period) shall:

(a) ☐ be forfeited on April 1 of the following Plan Year

(b) ☐ be carried over to the following Plan Year to reimburse Participants for Eligible Medical Expenses incurred during subsequent Plan Years

(c) x be carried over to the following Plan Year, up to a limit of $_____

11. **Death**: Participants who are Eligible Dependents shall continue to receive Benefit Credits after the Eligible Retiree's death:

(a) x Yes

(b) ☐ No

12. Catastrophic Coverage Reimbursement.

(a) Participants who are Eligible Retirees and/or Eligible Dependents shall receive Catastrophic Coverage Reimbursement for qualifying prescription drug expenses:

(1) x Yes

(2) ☐ No

(b) If Item (a)(1) is checked, the Catastrophic Coverage Reimbursement will begin only after the Participant incurs the following qualifying prescription drug expenses for the applicable Plan Year:

(1) x After the Participant has accumulated covered Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by CMS for the applicable Plan Year.

(2) ☐ After the Participant has accumulated covered Part D expenses in an amount equal to $ _____ for the applicable Plan Year [which must be higher than the limit set forth in (b)(1) above].

(c) If Item (a)(1) is checked, the Catastrophic Coverage Reimbursement benefit will be administered based on one of the following options:

(1) ☐ Option One. A one-time contribution equal to $_____ will be made to the Participant's HRA Account for the applicable Plan Year after the Participant has reached the level set forth in (b)(1) or (b)(2).

(2) ☐ Option Two: The benefit will be administered as a pool of benefits for all qualifying Participants as set forth in the SPD, and the pool for each applicable Plan Year will be $_____.

(3) x Option Three: Once the Participant has reached the level set forth in (b)(1) or (b)(2), all eligible claims for qualifying prescription drug expenses will be reimbursed for the remainder of the applicable Plan Year with no dollar limit.